social action

The High Cost of Health

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When illness strikes—an editorial

During recent discussions regarding a Blue Cross price rise in Ohio television interviewers asked people on Cleveland streets for their opinions. One father of three children indicated that it would be difficult for him to pay the higher price, then added, "But I can't afford not to have insurance."

This writer in recent months has been in many small circles of ministers and laymen where discussions centered around the question, What are the major social problems in your local community? One of the answers frequently given had to do with the need for adequate health care.

Should the church be concerned about the high cost of health? In February 1960 the General Board of the National Council of Churches unanimously adopted a pronouncement on the Churches' Concern for Health Services. On the subject of financing health services this pronouncement says:

> It is now widely recognized that the health of people is an important national resource, and therefore government has increased its responsibility for the maintenance of optimum health. The churches' concept of man, centering upon his creation and redemption by God for a divine purpose, imposes a more fundamental obligation for the furtherance of health. Therefore, the availability and financing of medical care of high quality is of deep concern to the churches.
>
> With the rising cost of medical care, serious or extended illness has imposed economic burdens which are beyond the capacity of many individuals and families to meet from current income. There is need for churches and church members to study the economic aspects of health services.
>
> Experimental patterns of health service, such as group health programs under the auspices of labor, management or other responsible volunteer associations of people, deserve encouragement. Flexibility on the part of all health professions and the public; willingness to try new methods; cooperative planning, analysis and evaluation are required to meet the needs of people. Continued growth of prepayment methods shows promise of ensuring high quality of medical service. The churches should encourage the inclusion of mental, dental, nursing, and other health services in programs of prepaid care, and the extension of the

amount and kind of care available to retired and other aged persons and to persons living in rural areas. If voluntary prepayment plans cannot accomplish the desired ends, government should protect the health of the people by making possible the prepayment of health services.

This last sentence may raise some eyebrows! Yet some examination of the facts will show that persons with limited incomes are hard pressed when illness strikes. Since both political parties considered a particular category of medical care a major campaign issue we can be sure that much attention will be given to this theme in coming months.

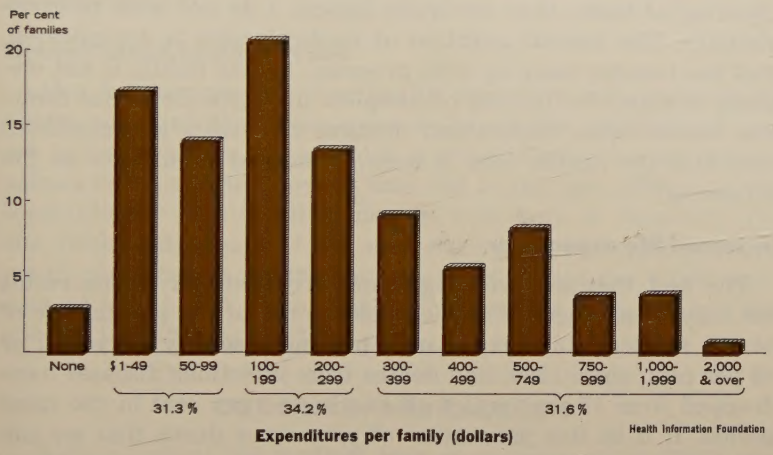
It will be seen that different points of view are expressed in the three articles which follow. Mrs. Mathiasen offers important information about problems aging persons face. Mr. Bugbee seems convinced that the cost of health services is not excessive, and that government help would mean undesirable controls. Dr. Gibbons, on the other hand, thinks the British health program, which has government support, has great merit! Here is material for some fine discussions in social action circles. Add Dr. Means' book (see book review section) and you will be sure to find this subject very exciting.

Lest there be any doubt as to the position taken by the Council for Christian Social Action we would mention a statement issued last June. It said, in part:

> The Council . . . favors legislation designed to provide insurance against the costs of hospital, nursing home, medical and surgical services for all retired and disabled persons, and urges favorable consideration of such legislation. . . . We would encourage the purchase of voluntary private health insurance by those who have the means to do so. But we must not lose sight of the inadequacy of these programs to serve many of the neediest cases, and we should recognize the responsibility of all citizens in our industrialized society to share in meeting the health needs of those whose limited resources cannot be expected to pay for adequate insurance. We believe the costs of medical service to these persons should be met in the most equitable manner possible, either through the social security system or through a program of general taxation, so that no aging person shall ever lack proper care because of economic inability or be subjected to indignity in order to qualify for it.

—F. Nelsen Schlegel

The high cost of health



Is medical care too expensive? Are health costs likely to rise even more?

These questions are asked by every American family, and in these times of steadily rising costs of living they seem to come up with greater frequency than in the past. This is true because costs are higher and families are using more medical care than they did even five years ago—and consequently spending more for it.

But if as a nation we are healthier and living longer, why is it we use more medical care rather than less? Moreover, if we look at the question superficially, it would seem that a greater

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By George Bugbee, President, Health Information Foundation, 420 Lexington Avenue, New York 17, N. Y.

volume of medical care would tend to bring unit costs down, as is often the case with other goods and services we buy. Yet even with increased volume medical costs rise further. Why?

REASONS FOR RISING COSTS

There are a number of reasons for the continued rise in medical costs; and, even though the average family has little understanding of them, they are quite logical. I do not wish to oversimplify. The overall question of medical costs is complicated, and has become more so with progress. So the public is not entirely to blame for its lack of complete understanding. But families would better understand medical care costs and problems that face the health field if they considered such facts as the following:

Increased life expectancy

The fact that we live longer and are healthier is the result not only of advances in medical science but of our greater use of health services. Life expectancy has increased by 22 years, or 49 per cent, since 1900; and deaths from infectious diseases have dropped from 18 per cent of all deaths to 1 per cent in the same period. It is in this prevention of premature death that we can tell how far medical science has progressed and how well we make use of its benefits, even though we tend to take the vast improvement for granted. We feel we have a right to longer, healthier life and quickly accept it as our just due. But these improvements did not come by coincidence or chance.

Advances in medical science

Medical care has become more "efficient." Recoveries are not only faster but in many instances more thorough or complete; pain has been greatly diminished; time away from the job because of sickness has been greatly reduced, and the risk of long or permanent disability has been lessened.

Methods of treatment are constantly moving ahead as a result of advances in surgery, new drugs and improved facilities. In other words, medical care can do more for us and is worth more. This does not mean, however, that illness has been eliminated, or that when sickness or accidents come our way we re-

quire less attention. On the contrary, the range of *treatable* illnesses has expanded, and with longer life has come an increase in the chronic or long-term diseases of old age. It does not necessarily follow, then, that because we live longer we can do with less medical care; or that because we know how to cope with a certain disorder we can strike it off our list. The control of pneumonia, for example, for which death rates have been reduced 57 per cent since 1940, still requires medical care for its accomplishment.

Greater use of health services

Also, because we are more health conscious and on the whole better educated than people were only a few generations ago, we voluntarily use more health services. Families visit doctors almost twice as often now as they did in the late 1920s, and almost 100 per cent of all babies are now born in hospitals. (In the 1930s, only about 37 per cent were born in hospitals.) One could cite other examples, but the point is that the whole concept of health and use of health services has changed, and the change has affected medical costs.

CRITICISM OF MEDICAL COSTS

A close look at the medical care component of the Consumer Price Index maintained by the United States Bureau of Labor Statistics would indicate that much of the criticism of medical care costs is unfair. In the past twenty years, the cost of all items that make up the family budget has increased about 100 per cent. Physicians' fees, on the other hand, have increased somewhat less, and drug prices have increased by a much smaller percentage. It is true that the cost of hospital care has increased a worrisome 300 per cent. But in combining all medical care components we find that unit costs for the family have increased slightly less than the total for all cost-of-living items.

What price indexes do not show

There are limitations to comparing price indexes. For one thing, such indexes can hardly reflect the revolution in medical care we have seen in the past twenty years or give any measure of the value of the antibiotics developed during the period. In

other words, price indexes do not show improvement in the *quality* of services; nor can they truly measure such changes as form, frequency, or efficacy of treatment. But even if we could momentarily disregard such advances, the price index would hardly validate criticism of medical prices.

Increased units of medical service

Unit prices do not seem to have increased excessively, and this is important: just as the electrical industry prides itself on the great reduction in price of a kilowatt hour (6.6¢ in 1928 down to 2.55¢ in 1958 for residential use) despite our greater use of appliances such as air conditioners and food mixers—so it is that increased units of medical services and the required newer services explain much of the change in total expenditure. As we have seen, that total has gone up materially, and for very good reasons. Not only are services better than and different from what they used to be, but we also use more units of service —more visits to doctors, more admissions to hospitals and more drugs.

GREATER ABILITY TO PAY FOR MEDICAL CARE

Moreover, we are better able to pay for medical care than in the past. At one time it was believed that many went without medical care because they could not afford to pay for it; as a result it seemed that much illness was unnecessary, and there were heated debates over whether or not the nation should have a system of compulsory health insurance.

Improved income distribution

Today the situation is very different. The United States has the highest average income of any country in the world, and there is promise that personal income will continue to rise at the same tremendous rate we have seen in recent years. Also, economists say that the distribution of income among the total population is improving and will continue to improve. Improved income distribution, in turn, means a better distribution of medical care. While in the early 30s persons with incomes of $5,000 or more made half again as many visits to doctors as did those in the lower income categories, recent figures show little varia-

tion in physician visits between the lowest income group and the highest.

Increase in "discretionary funds"

Average gross income per family last year exceeded $6,000, compared with a 1929 income of just under $4,000 (measured in comparable dollars, which means that adjustments have been made to account for inflation). Economists say higher personal income levels mean there is more money for discretionary spending—that is, spending beyond the basic necessities. The so-called discretionary funds, in fact, have increased more, proportionately, than total income. So the family market basket includes more steak and fewer potatoes than in years past; and there is more money available for luxuries, savings, emergencies and other areas of expenditure that are considered above and beyond necessity. By the same token, a certain amount of our medical expenditure goes beyond basic emergency and life-saving care—for greater comfort during illness, more reassurance and added convenience. And, if anything, our standards and expectations in these areas continue to rise.

Government at all levels, business, and philanthropy combined spend about 6 billion dollars a year in providing medical care; in addition, personal expenditures for such care now total another 19 billion. The grand total of slightly over 25 billion is impressive when you compare it with the estimated 3 billion spent in 1929.

While medical expenditures made up but 3.8 per cent of all consumer expenditures in 1929, they now constitute 5.5 per cent of a much higher level of economy. The public has substantially increased its investment in medical care, and we can take satisfaction in the fact that people consider it increasingly important and necessary to do so. At the same time, it is understandable that increased spending has generated concern—especially at a time of increased public interest in health affairs.

Role of voluntary health insurance

Voluntary health insurance, still gaining ground, has helped families a great deal in meeting medical care costs. Altogether about 124 million Americans are meeting some portion of their total medical bills through voluntary health insurance; and this

fact enables families to buy more of the services they need even in the largely uninsured categories, such as dental care, drugs, and hearing aids and other appliances.

Enrollment figures, however, are only part of the story. The range of benefits as measured in dollars paid has increased even more rapidly than enrollment. Of the 19 billion dollars spent by consumers for medical care, over 4 billion or 25 per cent are derived from insurance covering enrollees primarily for hospital costs and for doctors' services in the hospital. It would be unrealistic at this stage to assume that such coverage is always sufficient for the relatively few families who incur very high costs in a year. (Ten per cent of our families with such high costs in any year account for 40 per cent of all medical care expenditures.) But the range of coverage is expanding and health insurance agencies are aiming toward greater protection against the risk of higher or so-called catastrophic costs for the small percentage of families likely to incur them.

THE QUESTION OF GOVERNMENT PROGRAMS

Progress in extending benefits in the last decade alone shows that health insurance agencies are working in the right direction by making coverage more comprehensive. Health insurance benefits—as shown by a nationwide Health Information Foundation survey—increased an astounding 107 per cent from 1953 to 1958. In spite of such facts, there are some who maintain that it would be better to allow the Federal Government to handle the nation's health finances. It is a crucial issue on several counts, but particularly so because a government system would mean control, not only over total expenditures for medical care, but inevitably over those who provide health services and over the hospitals and other facilities in which they work.

A government health program, we must remember, cannot be structured like a program for Social Security pensions. It would require—if it were to function at all—that government organize and control those who would provide the services the government would guarantee. Controls would be necessary, then, but we don't know what those controls would properly be or even if they ever could be applied wisely.

Dangers in arbitrary control

Medical care is not readily adaptable to standardization, and there is danger in imposing arbitrary control over a profession that progresses most rapidly when it is free and unfettered. In my opinion, criticisms of the health field in other nations—especially criticism related to the cost of medical care—have led the public to yield control to government unwisely. I say *unwisely* because government operation is unlikely to solve the problems that face us today. It is a myth that a government program can provide "free" care for all, for there is no such thing, and it is pure fantasy in a nation with medical standards as high as ours to suppose we could greatly curtail expenditures through government programming without sacrificing the quality of care we want.

In the long run, the public must pay for medical care in some way. So the real question becomes one of quality under a national system and what progress may be expected when professionals are denied autonomy in their chosen field. But the public must decide for itself, and this is why I believe it is important for all families to understand the function of health services and why good medical care is never inexpensive.

Limitations of voluntary insurance plans

It is fair to say that voluntary health insurance falls short of meeting all needs. Families in this country run the whole gamut of costs, ranging from no expenditure in a year for medical care to relatively high costs. About 11 per cent of all families have medical expenses of more than $500 per year. A large part of this cost is for home and office medical care, diagnostic tests, drugs and miscellaneous services which for many of these families represent unpredicted and unusual expenditures. Currently the more common types of group coverage for hospital care and in-hospital physicians' services do not cover more than a third of the full range of family medical expenses. There is little question in my mind that insurance should not be expected to cover all expenditures; on the other hand, insurance should protect families incurring high costs. Voluntary health insurance historically was aimed at expenses in the hospital, largely because it was practical to administer such insurance; now it is recognized that much more attention must be given to the whole

risk for all types of expenditures that accumulate for some families.

ARE HEALTH SERVICES OVERUSED?

The possible overuse of health services—in spite of the clamor it sometimes stirs—is undocumented. From almost any point of view the increased use of available services seems only to represent progress. For example, accident cases alone account for 18 per cent of the increase in rate of hospital days. There are also large increases in the rate of use of general hospitals for heart surgery and for the treatment of mental illness and the chronic conditions of older people. Not incidentally, the rate of admission for what were once the most common surgical procedures—tonsillectomies and appendectomies—is about one-third what it was 25 years ago

No study so far has shown that health services are underused or overused by our population; but, if anything, death and illness figures for many diseases seem to indicate that we could have an even better health record if we took greater advantage of the health services presently available. Our health levels are among the highest in the world, but there is room for improvement in certain disease categories, among the elderly, and within some relatively less educated, rural segments of the population.

I have already said that hospital care is much more generally used throughout the population; yet the increase as represented by national figures does not seem out of hand. Does it not seem even less so when we consider that the public today more often expects hospitalization not only in times of life-saving emergency, but for greater safety, comfort, reassurance and convenience as well?

CONTINUED COST RISE INEVITABLE

We must be ready to accept the fact that the costs of medical care, at least in the years immediately ahead, will continue to rise. It is only realistic to assume that physicians' fees will probably follow price trends for services in general; that hospital rates will continue to rise, particularly as a result of hospital wages that are gradually approaching prevailing levels in other

areas. Prices for prescription drugs, although they have remained largely stable in recent years, will probably follow the same patterns. In our rising economy such increases are inevitable, as are contemporary increases in the costs of most consumer goods and services.

How long medical costs will continue to rise is, at best, unpredictable; but, since they follow the trends of our overall economy, we must expect that they will level off or stabilize only as other costs do.

Use of services will also continue to rise and the demands for medical care will increase as the nation takes greater advantage of the benefits medical science has to offer. With the aging of our population and an increase in degenerative diseases which require medical care over long periods, there is bound to be an increase in units of service per thousand population. Population increases will also necessitate more spending. Progress in education and improved standards of living—particularly among rural, low-income, Negro and other segments of the population that do not presently use large amounts of medical care—will bring further increases. Finally, the public's increased understanding of medical care and an improved perception of needs will add to the total.

SUMMARY

To summarize briefly: The rising cost of medical care in this country has created public concern on several counts. My belief is that if we as a nation had adequate understanding of the reasons for medical care costs, in general, we would see that prices in this area have not gone up excessively, and that the results of increased spending justify our investment.

It is true that the health field has problems to solve in the years ahead, including the continued improvement of voluntary health insurance, but the fact remains that our medical standards are the highest in the world and our rate of medical progress is the most rapid.

Health care for the aging

The questions of providing and financing health care for older persons are extremely complicated, as indeed they are to a lesser degree for all ages in the population. The problem with respect to older people differs in degree rather than in kind. It arises from the fact that costs are increasing at the very time when people are most likely to need medical care but least able to pay for it, since retirement income is much lower than normal earnings.

BACKGROUND OF THE SOCIAL PROBLEM

Traditionally, health care has been an individual and a family problem. To understand why health care for older people has become a recognized social problem of national concern, some background information may be helpful.

The United States Bureau of the Census predicts an increase of persons 65 and over from 15.8 million in 1960 to 19.5 million in 1970, to 24.5 million in 1980, to 35.2 million by the end of the century. Even more significant from the health point of view is the projected increase in the number of persons 75 and over—from 5.5 million in 1960 to 7.3 million in 1970, to 9.2 million in 1980, to 16.5 million by the end of the century. Forty years from now the population 65 years of age and older will have doubled, but the population aged 75 and older will have nearly tripled.

Income level of older people

In January 1960, the U. S. Census Bureau released the information that in 1958 nearly 60 per cent of all persons 65 and over received less than $1,000 in cash income per individual; and that between 20 and 25 per cent received between $1,000 and $2,000.

So far as assets are concerned, a survey made for the Federal

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Reserve Board early in 1957 revealed that 45 per cent of all spending units headed by persons aged 65 or over had financial assets of less than $500; and that 35 per cent had $2,000 or more, including 11 per cent with holdings of $10,000 or more.

In June 1958, only one in every five persons 65 and over had a paying job. About 28 per cent of all aged persons were drawing social security benefits (averaging about $66 per month) and about 16 per cent were receiving old-age assistance payments (averaging about $61 a month).

For the future, there are trends in two directions so far as income of older people is concerned. On the one hand, there are increasing numbers covered by social security, and about one-third of the work force is already covered by private pension plans. The most favored group, those having both social security and private pensions, usually have retirement income of about 40 per cent of their normal earnings. On the other hand, there is the long-run inflationary trend.

The fact that by 1980 nearly two-thirds of the total over-64 group will be 70 or over will mean not only a decline in work force participation but also an almost certain increase in the proportion of older people requiring extensive medical services.

NATURE AND EXTENT OF HEALTH PROBLEMS OF THE AGING

It should not be assumed that all elderly persons are sick, or that old age and ill health are necessarily synonymous. The significant factor, so far as medical costs are concerned, is that the illnesses of older people are apt to be chronic in nature rather than acute. The aged spend more than twice as many days per capita in general hospitals as do population as a whole.

Although information about nursing home care is incomplete, a 1953-54 survey of nursing homes found that 90 per cent of the patients in proprietary nursing homes were aged 65 and over. Only one-half could walk alone, and one-fifth were bedfast. Eighteen per cent of the patients had been in their present nursing homes for three years or more. A study of OASI beneficiaries showed that 67 per cent of all recorded stays in nursing homes were for more than sixty days and many were for a full year. Only 13 per cent of those who had been in nursing homes had been there for less than thirty days.

SOME EFFORTS TO ALLEVIATE THE CRISIS

In the light of the foregoing, we see why the problem of financing medical care for the aged played so prominent a role in the last Congress, as well as in the Presidential campaign. Many bills were introduced, and their provisions were complicated and varied.

Proposed legislation

The bill sponsored in the 86th Congress by Senator Patrick V. McNamara (Democrat, Michigan) proposed to provide 90 days a year hospitalization; 180 days nursing home care (or two days for each unused hospital day); 250 visits a year (or 2 2/3 visits for each unused hospital day) of home health services such as those of homemaker, physical therapist, visiting nurse; some X-ray and laboratory services; all drugs used in hospitals and some others. It proposed to cover virtually all persons aged 65 and over, including Old-Age Assistance recipients. It would have been financed under Old-Age and Survivors Insurance for those eligible for such benefits. For Old-Age Assistance recipients and others payment would have been made from general revenue funds. The estimated cost was from $1.1 billion to $1.5 billion per year.

The so-called "Administration bill" proposed 180 days of hospitalization; 365 days of nursing home care; 365 days of home health services; unlimited surgeons', physicians', and dentists' fees; laboratory fees to $200; and drugs up to $350. An option to all of these benefits was a cash subsidy of 50 per cent of the premium (up to $60 per year) for a private major medical insurance policy. Those eligible were to be persons over 65 meeting a means test: (a) those not paying income tax in the preceding year; and (b) those with income not exceeding $2,500 per year (or $3,800 for couples). The program was to be financed from general revenue funds through federal grants to the states averaging 50 per cent. Each state was to set up its own program and apply for federal grants. Estimated costs per year, $1.84 billion.

Amendment to the Social Security Act

Actually, of course, neither of these bills was passed, and though in the confusion of the final days of the Congress an

amendment to the Social Security Act providing "medical Assistance for the Aged" was voted, few people apparently were able to follow the details of the compromise measure or are indeed aware that the new law exists. Since to carry out the provisions of the law, state action is required and the states now have the matter under consideration, a brief reminder of its contents may be useful. The significant factor is that the law establishes a new category of the "medically indigent" who may receive medical care under the Old-Age Assistance Program.

It should be noted that the provision of federal funds for medical care for Old-Age Assistance recipients is not new; most of the states now pay certain medical costs either as direct money stipends or as payments to vendors of medical services.

The new departure in the federal law was the provision of medical services for aged persons *other than OAA recipients.* This legislation provides that the Federal Government will pay from 50 to 80 per cent of the amounts spent for medical services for "medically-needy" aged individuals. It is left to each state to decide whether to add this feature to its existing public assistance program, what will be the criteria for eligibility, and the type and extent of medical care to be provided. Actually, to date, not many states have made the necessary appropriations to take advantage of this matching-grant federal program. Some have deferred enabling legislation until the beginning of the new Administration in the belief that the subject will come before the Congress again in 1961.

Non-governmental insurance

Many employed persons are, of course, covered by hospitalization insurance during their working years. According to a report issued December 4, 1960, by the U. S. Public Health Service, two out of three Americans had voluntary health insurance in 1959. Among persons 65 and over only 46 per cent had hospital coverage, 37 per cent had surgical coverage, and 10 per cent had insurance for in-hospital physicians' fees.

Until recently health insurance for those already 65 and over was unobtainable. New types of coverage are now being tried out by some Blue Cross Plans and by a few insurance companies. A group plan for an association of retired persons is fairly typical. The annual premium per individual is $72. The plan pays $10 a

day for 31 days per illness, 50 per cent of miscellaneous hospital expenses or of emergency out-patient hospital care for accidents, up to a total payment of $125, and surgical expenses with a $200 maximum fee schedule. With hospital care averaging $20 or more per day in most hospitals, it should be noted that the benefits cover about half the hospital costs.

The role of the family

There is sometimes a tendency to believe that families are less willing to assume responsibility for their aging members than in an earlier day. A recent study by the National Opinion Research Center at the University of Chicago would indicate that this is not necessarily true. The report points out that about 22 per cent of older people have no children. However, it goes on to say, in substance:

> More than one-third of those older persons who have living children reside in a household with at least one son or daughter. Older people who do not live with their children are not as a rule physically abandoned but live near enough to at least one son or daughter to facilitate frequent visits.
>
> The poorer the health of the older person, the more likely he is to be living in the same household as an adult son or daughter. Whether this is a good or a bad thing for parents and children cannot be answered categorically. Each such family situation must be analyzed in terms of its unique characteristics and the personalities involved.
>
> The data indicate that, when confronted with parental health problems, children assume the obligations traditionally associated with the relationships of aged parents and adult children.

TRAGEDY MULTIPLIED

What this family responsibility may mean in some instances was pointed out by a collection of cases compiled by the YWCA in connection with Congressional hearings on financing health care for the aged. These cases are graphic illustrations of the problems that confront elderly people and their children in the face of a long-term illness, no matter how conscientious the children may be. The paragraphs quoted below give some idea of the stresses that may be involved:

My 85-year-old mother had a stroke in 1952 and broke a hip in 1955. She broke the other hip in 1959. We had to pay $3,000 exclusive of doctors' bills when she was in the hospital. Now we pay $250 a month for nursing home care. My mother had to cash in everything she had. There are no relatives to help her except me. The total cost over the past 8 years amounts to $15,000. All of my family were affected by these expenses and the emotional burden has been great.

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My 67-year-old mother-in-law had been living at home with us. She had a $500 insurance policy, no savings and no income, because she was widowed at an early age and raised her children by keeping house for her father, a single brother and sister. She had no position that entitled her to any social security or pension. When she was stricken with a brain tumor . . . the family pitched in until there was no reserve.

After endless tests and operations she was released and we had her at home for months. Home life ceased. My children were 7 and 9 years of age. Tempers were short and tensions strained. Finally, arrangements were made to put her in a nursing home. We pay part of the bill and my sister-in-law pays an equal portion.

My mother-in-law, incapacitated physically, can move only when supported by two people, one on each side, to balance her. Although the doctors said she would live only a short time, she has been in this condition to date for 8 years. I couldn't begin to estimate the amount of money that her illness has cost.

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The last six years have been a bad dream. Our family has been torn apart because we were not able to afford the kind of special care that my elderly mother needed and so tried to care for her at home. Four lives were damaged in the process. The seven-year-old developed colitis, the other brother said he wanted to stay away from home as much as possible and my husband said he would take a room in New York.

This brief review of some of the basic considerations and problems in medical care for older people and some of the currently proposed actions makes no attempt to propose a solution. It is presented in the hope that it may stimulate a more enlightened citizen concern with one of the most pressing social and economic problems that confront families in our society today.

What can we learn from

The national health service of Great Britain?

Many Americans will be surprised to learn that the National Health Service of Great Britain now provides medical care and hospitalization more widely, more economically, and more satisfactorily than has been done at any previous time in that nation's history. What may surprise some members of the medical profession is that doctors in Great Britain have on the average higher incomes than the members of any other profession. They now widely acclaim the advantages and values of the governmental program. The Health Service is there to stay.

Does the experience of Great Britain contain any lessons for the United States? On this side of the Atlantic there is a growing realization that the costs of medical care and hospitalization for the aged should be provided through some form of compulsory prepayment plan under governmental regulation. Great Britain makes this provision for all ages, distributing the costs among all earners and taxpayers and providing the services under governmental direction.

HISTORICAL BACKGROUND

What considerations led the British people to adopt this compulsory, nationwide program?

The system did not begin with the passage of the National Health Service Act in 1946, but had antecedents in the voluntary and compulsory workers' health insurance plans. In the nineteenth century medical insurance was provided by the Friendly Societies formed by the labor unions under stimulation from the non-conformist churches. Toward the latter part of the century there arose Medical Aid Societies which not only provided insurance but also supplied many of the medical services.

By Ray Gibbons, Director, Council for Christian Social Action.

In 1911 Mr. Lloyd George put through Parliament a measure which required all wage earners to contribute toward health services. This provided insurance for the wage earner but not for his family. Employers and government made contributions to supplement those of the workers. Doctors were paid by the government in accordance with the number of patients on their lists rather than the specific services rendered. At first there was much criticism of the plan from the medical profession, but the program initiated when the Conservative Party was in power was not changed when the Liberal and Labor Parties were in control. The satisfaction of the people with compulsory prepayment for medical services became the corner stone for later developments.

Impetus from World War II

The second World War revealed many serious deficiencies in the health of wide segments of the population in Great Britain, as in other countries. Voluntary hospitals which had been organized to give free service to needy people were unable to meet the demands of the wartime situation and the rising costs of medical care. Therefore, the government had to reorganize the hospital services to provide wider coverage and to meet the threat of bomb damage in the cities. Furthermore, the government began direct payments to hospitals for the treatment of civilian war casualties. This required the hospitals to introduce better accounting procedures in order to make a fair charge for services rendered.

But something more was happening than the meeting of an immediate emergency. Along with these wartime innovations, an improved social outlook was developing. The wartime growth in national solidarity was accompanied by a deepening of mutual concern among the people. There were many who realized as never before the needs of their neighbors for health, education and security. The war not only accelerated the development of medical science and technology but also quickened the people's conviction that health was an attainable national goal. So it was that—building upon experience with voluntary workers' insurance and with wartime exigencies—Parliament, in 1946, adopted universal compulsory insurance under the program known as the National Health Service.

THE NATIONAL HEALTH SERVICE AND SOCIAL JUSTICE

The health program in Great Britain finds strong support in the moral consciousness of the British people. It appeals to their sense of social justice to know that every citizen, indeed every resident in the islands, can have medical care whether or not he can afford it at the time it is needed. "Health is a right and not a charity" is a widespread conviction of the people. "The National Health Service is an excellent program, and every country ought to have one," declare both patients and doctors. Health services, like education, help to enable people to become productive members of society and contribute to the strength of the nation. They are not a luxury but a necessary investment in the nation's manpower.

Equal opportunity for health protection is a corner stone of the program. It has improved the provisions for hospital and medical care for farmers, as well as for dockers and factory hands. General practitioners are now available in rural areas as in the heart of London. This effort to provide equal opportunity not only covers general medical and hospital services but extends to dental and opthalmic services as well.

Individual freedom retained

Along with the effort to provide health services for all who need them has gone the demand to preserve individual liberty and improve the relations between doctors and patients. Every person may choose his own doctor and may change doctors if he desires. Similarly, doctors may change their patients. Any person may use the health services as much or as little as he wishes; and he may supplement them with private services for which he personally pays.

Doctors are paid in proportion to the number of patients on their lists. The maximum is 3,500 persons, and there are special inducements to keep the number between 500 and 1,500; but in addition to what he does for the Service any doctor may also have private patients and receive additional fees for his services to them. If a person desires a private nurse, or a private room in the hospital, he may pay the extra costs without losing his rights in the Service. This freedom is part of the moral foundation of the system as certainly as is the equal claim of all upon its services.

Moderate costs maintained

The costs of the services have not been exorbitantly high. Estimates made prior to the inception of the program fell short, by about 50 per cent, of what the actual costs turned out to be. One reason for this underestimate was the unexpectedly large backlog of unmet need. People who had never had adequate dental care now availed themselves of the new opportunity. Others secured long-needed eyeglasses.

Although the bulk of the expense was due to genuine need, there undoubtedly were many who sought services that were not essential. Hence a few charges have been introduced—primarily for their deterrent effect: e.g., one shilling (about 14¢) is now charged for each prescription filled at the druggist's, and one-pound (about $2.80) for dentures. Lenses may be obtained free, but the frames are purchased. These expenses are not prohibitive but they have helped to correct early abuses of the system.

No inflationary increases

Costs have not increased markedly since the beginning of the program. In his Sherrill Lectures at the Yale Law School, Richard M. Titmuss, Professor of School Administration at the University of London, reviewed the question of costs for the services. He pointed out that there was an early demand upon the system to raise the salaries of nurses and other hospital workers, and a later one to increase the income of doctors. In spite of these increases, the per capita rise in cost was negligible.

> The rising cost of the Service in real terms during the years 1948-54 was kept within narrow bounds. . . . Any charge that there has been widespread extravagance in the Service, whether in respect of the spending of money or the use of manpower, is not borne out by our evidence. . . . The cost per head of the population at constant prices was, in fact, almost the same in 1953-54 as in 1949-50 (the first full year of operation). Moreover, the proportion of the total national resources (the gross national product) paid for by public authorities fell from 3¾ per cent in 1949 to 3¼ per cent in 1953-4. All the estimates I have seen of the proportion of national resources devoted to medical care in the United States give higher figures, and also show that the cost per head of the population has risen significantly since 1948.[1]

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1 Richard M. Titmuss, *Essays on "The Welfare State"* (2d ed.). London: George Allen and Unwin Ltd., 1959, pp. 148-9.

In interpreting this conclusion that the cost of the Service has been kept within narrow limits the following summarized facts should be borne in mind: in proportion to the populations at risk over the six years the hospitals did more work both in-patient and out-patient; more doctors (especially consultants), nurses, social workers, administrators, physiotherapists and other professional staffs, later to engage in private practice or other employment at home or abroad, were trained at public expense; more confinements took place in hospital; more road accidents were treated; more provision was made for industrial accidents which would otherwise have called for an expansion of health services organized by employers; a great increase took place in the use of X-rays, pathological and diagnostic services; more of these services were made directly available to general practitioners (in part a switch from the doctor's private practice expenses to the hospital service); the number of voluntary blood donations rose dramatically by over 300,000 to 760,000 in 1955; a larger proportion of those in need were fitted with hearing aids, artificial limbs, spectacles and dentures; more drug prescriptions were issued; more home helps and nursing services were provided for those who were ill at home; more doctors worked as Health Service practitioners; there were fewer singlehanded practitioners and more partnerships and group practices; the average number of people on a general practitioner's list fell; a substantial improvement took place in the geographical distribution of general practitioners and consultant services; finally, more medical research was undertaken and completed, as indicated by a striking rise in the flow of articles to scientific and medical journals after 1948.[2]

At present the overall cost of the National Health Service is about 700 million pounds ($1,960 million). Of this amount about 150 million pounds is derived from charges and other sources and 550 million pounds from taxes. The per capita cost for medical services, including capital construction, is about 11 pounds per person per year ($30.80).

PHYSICIANS AND THE NATIONAL HEALTH SERVICE

The medical profession has not suffered under the program and seems generally to support it. There has been no shortage of young men entering the profession since the Service began and the supply of doctors in Great Britain now exceeds the de-

[2] *Ibid.*, pp. 149-50.

mand. The income of the medical profession is the highest of any professional group in Great Britain. The average general practitioner who has about 2,500 names on his list is paid 2,600 pounds a year (about $7,240).

Many physicians have private patients and receive special fees for maternity services, for treating temporary residents, for training assistants, for supplying drugs and appliances, for attending local authority clinic sessions, for infant welfare, vaccination and immunization services, for part-time school and factory work, and for hospital and specialist posts of various kinds. Doctors also receive favorable tax relief for many expenses of a semi-personal character. Those doctors who purchased their practice are compensated by the government; and when a doctor retires he receives an annual pension of approximately one thousand pounds a year (about $2,800), depending in part upon the number of patients he has carried on his list.

Prior to the initiation of the National Health Service program, about forty per cent of those doctors in private practice were in serious financial difficulty; and in some industrial areas there was severe poverty among them. After the salary scale adjustments made by the government in 1952 the *British Medical Journal* declared: "The controversy on finances between the BMA and the Ministry of Health has come to an end." As Mr. Titmuss states, "Whatever else may be said about the National Health Service, it can at least be concluded that, under the new regime, doctors have prospered."[3]

Doctor-patient relationships

In some respects general practitioners have more freedom to practice than ever before. They now have greater access to hospital and specialist services for their patients. As the Committee on General Practice, composed largely of doctors, reported:

> The Committee does not think that in general the advent of the National Health Service has disturbed the relationship between doctors and their patients . . . , the relationship is good; in some respects indeed, it was found to be better than before, and this was attributed to the absence of the money bar and to increased cooperation among doctors.[4]

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[3] *Ibid.*, p. 164.
[4] *Ibid.*, pp. 168-9.

Do general practitioners complain of an increased demand for services when they are not paid by the patient? "A detailed examination of all the published reports on the subject, including five large statistical studies on National Health Insurance before 1939 and six or so National Health Service studies after 1948 of varying quality, does not confirm this belief." The consultation rate for 1949-50 was 4.62 attendances and visits per person per year, while in 1930 it had been about 5.10 per cent. "The only conclusion that can be drawn from these and other statistical materials is that, on average and contrary to public belief, demand has not increased under the National Health Service and may indeed have fallen. . . . There is little evidence that demand is higher than in the United States."[5]

What has been increasing rapidly is the dependence of doctors upon specialists and special services, with a consequent widening of the gulf between the general practitioner and the specialist. This has put the general practitioner on the defensive. His patients demand expensive treatments which only the hospitals and specialists are able to provide. This loss of security and status is a matter for concern but it can hardly be attributed to the National Health Service.

> The widespread belief, especially among the medical profession, that the advent of the National Health Service led to an immense increase in work for general practitioners is thus not borne out by the facts—and particularly the published facts by the BMA itself.[6]

Nor has the doctor become a clerk filling out forms and signing certificates. Indeed it would appear that under the National Health Service demand for such paper work has decreased markedly. For example, in 1938-39, the average was 139 certificates per 100 insured persons; whereas, in 1952-54, the average per 100 was only 48.

IN CONCLUSION

These observations by a layman suggest that Great Britain's health system is the result of long experimentation with private and public medical insurance—prompted throughout by a strong

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5 *Ibid.*, p. 174.
6 *Ibid.*, p. 210.

sense of need for more adequate care; a powerful moral demand for equal opportunity, with free choice in securing health services; and the necessity of keeping costs within the ability of the people to pay.

Britain's system appears to be working to the satisfaction of the British people; and no political party proposes any drastic revision of it, much less its abolition. It may fairly be argued that our situation in the United States differs from that in Britain, or that our people are not ready to adopt so comprehensive a plan; but it cannot be argued that the health and character of the British people have seriously suffered because of the National Health Service, since both appearances and reliable studies indicate the reverse.

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book reviews

MAKING MEDICAL CARE BETTER AND LESS EXPENSIVE

Doctors, People, and Government, *by James Howard Means. Boston: Little, Brown and Company, 1953.*

It's Cheaper to Die, *by William Michelderfer. New York: Braziller, 1960.*

Family Medical Costs and Insurance, *by Odin Anderson and Jacob Feldman. New York: McGraw-Hill, 1956.*

The Crisis in American Medicine. *Supplement to Harper's Magazine, October 1960.*

Making Medical Care Better, *by Herbert Yahres. Public Affairs Pamphlet No. 283. New York: The Public Affairs Committee, Inc., 25¢.*

The Churches' Concern for Health Services. *A flier. New York: National Council of Churches, 1960, 10¢.*

For twenty-eight years the author of *Doctors, People and Government* was Chief of Medical Services at the Massachusetts General Hospital, and Professor of Clinical Medicine at Harvard.

His book has much to say to laymen about medical education, hospitals, and the work of doctors. It raises some serious questions about methods of paying for medical services and the degree of government participation in health programs. It also tells us that new doctors licensed each year are not enough to meet growing needs. And statistics like the following indicate the distribution of professional services: there are 175 physicians to 100,000 persons in the northeastern section of the country; only 75 per 100,000 in the Deep South; and 125 per 100,000 on the Pacific Coast. There are 325 nurses per 100,000 in New England; 150 per 100,000 in the Deep South.

Dr. Means has a good chapter about Britain's venture in government medicine, and then reminds us that there is much "free" medical care in the United States also. In 1955, 3% of our hospitals were operated by the armed services, and 8% were controlled by the Veterans Administration, for free service to veterans. Moreover, 58% of all hospitals in the nation are maintained by states or municipalities, and the Public Health Service is indispensable at many points.

This book pays much attention to the trend toward group health plans which have reduced medical costs, increased efficiency, and emphasized the practice of preventive medicine. It discusses the successful operation of the Health Insurance plan (with 550,000 subscribers in Metropolitan New York); the Kaiser Foundation Health Plan (with 600,000 subscribers on the West Coast) and other prepayment group programs.

On this subject Dr. Means says:

> I believe that payment for medical care on a fee-for-service-as-rendered basis is outmoded. It is not conducive to the best care of patients in present-day society. Instead I believe that prepayment plans, which afford benefits directly in the form of comprehensive service, are today the method of choice. . . . I think that doctors should preferably be paid by salary—adequate salary —or by salary plus a share of the earnings in the case of medical groups. . . . The time has come, because of the complexities of modern diagnosis and treatment, when medicine should be practised usually by groups of doctors, rather than by individual practitioners. . . . "Organization for medical care" is the generic term I would apply to all types of professional teams or groups.

It is obvious that Dr. Means and his book are not popular with many leaders in organized medicine! Yet he writes with much more tolerance of his opponents than does newspaperman William Michelderfer, author of the more recent *It's Cheaper to Die.*

This book discusses, not without strong feeling, such themes as the ways of the A.M.A. and of the Blue Cross-Blue Shield

insurance program, the high cost of drugs, fee splitting, and the crisis in hospitals.

This reviewer thinks Michelderfer's finest chapter is the one entitled "Is There a Shortage of Physicians?" The author questions the wisdom of employing thousands of poorly prepared foreign born doctors, many of whom know very little English, as interns and resident physicians in our hospitals. He is critical of the medical profession's tendency to specialize, so that there are few G. P.'s. And he emphasizes the doctor shortage with these words from a concerned G. P.:

> The thing that bothers me most is what to do with the emotionally disturbed patient. . . . As an overworked G. P. . . . how am I going to find the time to establish good doctor-patient relationships? The M.D. I can't find for this emotionally disturbed patient is the first-class psychiatrist who won't charge $25 a visit at his office. . . . And if you haven't the $25 an hour for his service my job is to find a good mental health clinic, where, if we are lucky, the waiting list is not over three months.

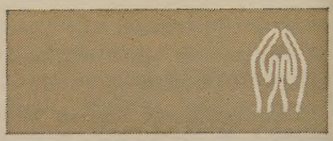
Family Medical Costs and Insurance is a very different kind of book. Full of statistics, it takes time for proper study and appreciation. The statistics show that prevailing health insurance benefits "cover approximately 50% of all private patient hospital charges, 38% of all surgical charges, and 25% of all obstetrical charges for the entire population. . . . The evidence is strongly suggestive that insurance influences the utilization of hospital care in that insured persons have an admission rate of 14 per hundred and uninsured persons a rate of 9."

The current debate on medical care is dramatically presented in a 48-page supplement to the October 1960 issue of *Harper's Magazine*. There are eight essays by doctors, journalists, a Rockefeller Institute professor, and a theologian (his subject is "The Patient's Right to Die").

The Public Affairs pamphlet deserves close attention too. It offers 28 pages of information about group plans, describing different types of plans and how they work in little places as well as in big cities. It answers many common questions, like: Does group practice allow free choice of physician? How about using specialists? What about help with mental health problems?

Finally, this review must mention the National Council of Churches' pronouncement on health services, part of which is quoted in the editorial section of this magazine. The pronouncement was written with the help of several physicians, and it received a unanimous vote of the Council's General Board. The whole piece should be studied by social action committees.

—F. Nelsen Schlegel



THE "FORCE THAT MAKES FOR HEALTH WITHIN US"

Scripture

(Suggested references are incorporated in the commentary below.)

Hymns

Healer Divine
Day Is Dying in the West
In Heavenly Love Abiding
O God, Our Help in Ages Past

Prayers

RECOMMENDED SOURCES: *Meditations for the Sick,* Russell Dicks (Willet, Clark & Co.); *Worship Aids for 52 Services,* Friedrich Rest (Westminster); *Healing of His Seamless Dress,* David MacLennan (United Church of Canada); *My Companion for Quiet Hours,* Armin F. Bahnsen (World Press).

One does not need to belong to the "Peace of Mind Cult" to realize the importance of the relation of faith to health. "Psychosomatic" may be a modern word but the ancients recognized its implications thousands of years ago. Our concern here is with the resources of Scripture for health. For the benefit of our study and devotions we list these under the topics: Preventive Therapy (before illness); Therapy (during illness); Supportive Therapy (prayer for others).

PREVENTIVE THERAPY

People of little faith are tense and fearful. As in O'Henry's phrase, they "like to back the hearse to the door" at the first sign of illness. Attitudes are important. Notice this passage: "In quietness and in trust shall be your strength" (Isa. 30:15).

One of our local physicians is gaining quite a following by using hypnosis in child birth. Patients say they feel no pain, only pressure. Part of the hypnosis is a series of relaxing exercises. This is the "quietness" of which Isaiah speaks. Doctors almost unanimously agree that patients who have "trust" (confidence, faith) are less subject to illness; and that, if illness occurs, they are far ahead of others along the road to health (wholeness). Pastors agree with this conclusion. Note these passages: Ps. 23; Prov. 13:13 and 17:22; Isa. 26:3; Matt. 6:31; Mark 6:31; Luke 17:21; Rom. 8:6.

By Alfred F. Schroeder, Pastor, Christ United Church of Christ (Evangelical and Reformed), Bellville, Ill., and a member of the Council for Christian Social Action.

THERAPY

There is a "force that makes for health within us." Physicians work with this force. "I dressed him, God cured him," testified Dr. Ambroise Pare. We can work with this force, too. Romans 12:2 suggests a strategy: "Be transformed by the renewal of your mind." This is the area where the Holy Spirit operates. He does something *in* us rather than *to* us. Consider these passages:

Ps. 27—for the fearful.
Isa. 40:28-31—for the weak.
Matt. 9:22—the place of faith.
Mark 2:5—for the guilty.
John 14:1—for the sorrowing.
Rom. 8:31—for the defeated.
Jas. 5:13—for the suffering.
I John 4:18—for overcoming fear.

Prayer: Almighty God and Merciful Father, who art the only source of health and healing, the spirit of calm and the central peace of the universe; grant unto us, Thy children, such a consciousness of Thine indwelling presence as may give us utter confidence in Thee. In all pain and weariness and anxiety may we throw ourselves upon Thy besetting care, that, knowing ourselves fenced about by Thy loving omnipotence, we may permit Thee to give us health and strength and peace; through Jesus Christ our Lord. *Amen.*[1]

[1] From *My Companion for Quiet Hours,* Armin F. Bahnsen (World Press).

SUPPORTIVE THERAPY

We send for the doctor in illness. Do we send for the pastor as well? Or request the prayers of others? In James 5:14, we read: "Is any among you sick? Let him call for the Elders of the Church and let them pray over him and the prayers of faith will save the sick man."

The nearness of pain or sorrow prevents some people from praying. We can "word their prayers for them." For many years I have provided a special prayer for others in the worship service. We do not advertise the number of people helped. On one occasion, a man whose daughter —suffering from an undiagnosed illness—was being transferred to a distant hospital at church time, found her much improved on arrival at the hospital. "I shall never doubt the power of prayer again" was the grateful father's testimony.

A typical prayer: "Our Father, into thy loving hands we give those who need an extra portion of thy spirit. We know that whatever we give into thy care is always well kept."

Program Planning

NOTE: The Program section of SOCIAL ACTION has been omitted because of space limitation. However, a column of program helps will appear in the April number of CHRISTIAN COMMUNITY.—EDITOR.

JUNE 19-23	Christian Social Action Institute, White Memorial Retreat Center, Mill Valley, Calif.
JUNE 19-23	Christian Social Action Institute, Blue Ridge Assembly of the YMCA, Black Mountian, N. C.
JUNE 19-JULY 1	Eighteenth Annual Race Relations Institute, Fisk University, Nashville, Tenn. Director, Dr. Herman H. Long.
JUNE 20-AUGUST 9	Africa Study Tour, forty-nine days in eleven countries. Leaders: Rev. and Mrs. Herman F. Reissig.
JULY 10-14	Christian Social Action Institute, Lakeland College, Sheboygan, Wisc.
JULY 24-28	Christian Social Action Institute, Massachusetts Congregational Conference Center, Framingham, Mass.
JULY 24-AUGUST 13	Caribbean Study Tour. Leader: Rev. F. Nelsen Schlegel.
AUGUST 11-15	Christian Social Action Institute for Young People (Midwest location to be announced).